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**Rhode Island  
Nursing Assistant Advisory Board**

Room 105  
3 Capitol Hill  
Providence, RI 02908-5097

***Instructions and Application For***

**License As A  
Medication Aide**

By Certification

For Individuals Currently  
Working as a Medication Aide

DO NOT REMOVE THIS PAGE FROM APPLICATION

*Applicant - Print Name (First, MI, Last)*

☐ Fee  
☐ BCL  
☐ Photo

Checklist

☐ Tax  
☐ Certificate  
☐ Tax  
☐ Proof of Age

OFFICE USE ONLY

# GENERAL INFORMATION

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## **Enclosures**

The following materials and information should be enclosed within this application packet:

Application Process Overview.....	4
Instructions for Completing Application.....	5
Application Checklist.....	6
Application.....	7-9
Mandatory Addendum to License Application (Social Security Number Verification).....	10

## **Licensure Requirements**

### **All Applicants**

- Recent passport type photograph (no photocopies).
- A Full Bureau of Criminal Investigation (BCI) Check (see application checklist - page 6).
- An original of certified copy of your birth certificate or government issued document verifying date of birth.
- Processing Fee: **\$40.00** Paid by Applicant (covers application processing and initial license).
- A copy of your medication aide program certificate.

### **Rules and Regulations/Laws**

The “Rules and Regulations Pertaining to Rhode Island Certificates of Registration for Nursing Assistants, Medication Aides and the Approval of Nursing Assistant and Medication Aide Training Programs (R23-17.9-NA)” can be obtained at the following web site:

<http://www2.sec.state.ri.us/dar/regdocs/released/pdf/DOH/5082.pdf>

Chapter 23, Title 17.9 entitled “Registration of Nursing Assistants” can be downloaded at the following web site:

<http://www.rilin.state.ri.us/statutes/title23/23-17.9/index.htm>

# GENERAL INFORMATION (CONTINUED)

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## **Initial License**

Once your completed application has been reviewed and approved, you will be issued your initial license. Please note: that license may expire within a few months or up to two years after your examination. Depending upon your expiration date, you may need to renew your license prior to the normal two-year expiration period.

## **Renewals**

A renewal notice will be mailed to you approximately sixty (60) days prior to the license expiration date. You must obtain the signature of an official in a **licensed health care facility** (i.e. nursing home) where you were employed as a Medication Aide within the 24 months prior to renewal. **If you document that you were working in a facility other than a licensed health care facility (nursing home, assisted living facility, or adult day care), you will not be eligible for renewal.** **YOUR REGISTRATION MUST BE ACTIVE DURING ANY EMPLOYMENT PERIOD VERIFIED BY YOUR EMPLOYER**

## **Continuing Education Credits**

Beginning 1 July 2010, licensees at the time of renewal, will need to verify a minimum of four (4) hours of continuing education credits in the previous two (2) years.

# APPLICATION PROCESS OVERVIEW

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The licensure process in the State of Rhode Island is conducted by the Rhode Island Department of Health (HEALTH), Office of Health Professionals Regulation, and the Rhode Island Nursing Assistant Advisory Board (Board).

## **Application Process**

In addition to the application, you must submit additional information directly to the Board. All items listed on the “checklist” (page 6) must be submitted for an application to be considered complete. **“APPLICATIONS ARE VALID FOR A ONE (1) YEAR PERIOD”**.

Please allow a minimum of 8 weeks for the entire licensure process to be completed. If you have a malpractice, criminal or disciplinary history in Rhode Island, or another state, it can take an additional 2 or 3 months for processing your application.

Licenses will be issued within 7-10 working days following approval of the license. Wallet-sized license cards are mailed within 3 weeks from the date of issuance, and are mailed to the address furnished in the application. You are responsible for notifying the Board office, in writing, if your address changes in the interim. The BOARD may be emailed an address change. The email address is located at the following web site:

[http://www.health.ri.gov/hsr/professions/n\\_assist.php](http://www.health.ri.gov/hsr/professions/n_assist.php)

***To obtain your license number prior to receiving your license card, please refer to the HEALTH Licensee Lookup web site:***

<http://www.health.ri.gov/hsr/professions/license.php>

HEALTH will not, for any reason, accelerate the processing of one applicant at the expense of others. Once completed, the application will be reviewed, and you will be contacted in writing. Be advised, you may be required to appear for an interview. NOTE: You may ***not*** practice in Rhode Island until you have received a license number.

Please continue to review the remaining portions of this application packet for instructions and other materials necessary to complete the application. If you have any questions about this application process, or would like to check on the status of your application, please contact the board staff at (401) 222-5888.

# INSTRUCTIONS FOR COMPLETING THE BOARD APPLICATION

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Read the following instructions and those throughout the application packet carefully before completing the application. **Only complete applications with the appropriate fee will be accepted.** Failure to submit all required information and appropriate documentation may result in processing delays.

## **General Instructions**

1. Make a copy of the application and forms before you begin in case you make a mistake.
2. Type your information or print in blue or black ball-point pen. HEALTH staff will not make assumptions about illegible information.
3. Provide a response to each section or question; otherwise mark "N/A" for Not Applicable.
4. We suggest that you make a copy of your completed application before submitting it to HEALTH.
5. It is your responsibility to check on the status of your application.

## **Completing your Application**

1. Complete the application pages (7-9 and 10). You must respond to all components of the application as instructed. If you attach separate pages in continuation of the application, such pages **MUST** clearly indicate the section for which such information is being reported.
2. Make a check or money order (in U.S. Funds only) for the application fee of **\$40.00** payable to the **General Treasurer, State of Rhode Island** and staple it to the upper left-hand corner of the first (Top) page of the application. This application fee is **NONREFUNDABLE**.
3. Complete all application materials as instructed and arrange them in the order listed on the application checklist (page 6). Do not submit the application without all applicable information, documentation and fee(s). Mail these components of the application to:

**Rhode Island Department of Health  
Nursing Assistant Advisory Board  
Room 105, 3 Capitol Hill  
Providence, RI 02908-5097**

## APPLICATION CHECKLIST

Please review the following checklist to ensure that all the components of the application process have been satisfied. Some items may not apply.

### Board Application

- ☐ I have read and understand the "Instructions for Completing the Application".
- ☐ I have completed the application as instructed (pages 7-9 and 10).
- ☐ I have completed Section 12, "**Affidavit of Applicant**", and have had the affidavit section completed and notarized by a notary public.
- ☐ I have attached a photograph to Section 13, "**Recent Photograph**" as instructed. I have verified that it meets the photograph requirements as stated in the application.
- ☐ I have attached a government issued document verifying my date of birth (i.e. birth certificate/driver's license).
- ☐ I have attached a copy of the certificate of completion of my mediation aide program.
- ☐ I have a **check** or **money order** (preferred), made payable (in U.S. funds only) to the "**RI General Treasurer**" in the amount of **\$40.00** and attached it to the upper left-hand corner of the first (Top) page of the application (All fees are NON-REFUNDABLE).
- ☐ I have arranged my Board Application materials in the following order.
  1. Fee (attached as instructed).
  2. Board Application (**including cover page**) (pages 7-9 and 10).
  3. Supporting documentation as required. [**Note:** Pages containing additional information in continuation of the Board application] **MUST** indicate the section for which the information is being reported.]
- ☐ I have mailed the above application materials directly to the Rhode Island Nursing Assistant Advisory Board.

### Additional Requirement for ALL CANDIDATES

I have requested a full Bureau of Criminal Investigation check (BCI) from the Attorney General's Office, 150 South Main Street, Providence, RI 02903 - (401) 274-4400 as instructed. **If you answer yes to question 10 on page 8, and you do not provide a complete explanation describing your criminal activity, your application will not be processed. If you do not complete the application process within six (6) months from the date of the BCI, a current BCI will need to be submitted before you will be licensed.**



# State of Rhode Island Nursing Assistant Advisory Board

## Application for License as a Medication Aide

Refer to the Application Instructions when completing these forms. Type or block print only. Do not use felt-tip pens.

### 1. Name(s)

This is the name that will be printed on your License/Permit/Certificate and reported to those who inquire about your License/ Permit/ Certificate. Do not use nicknames, etc.

Title (i.e., Mr., Mrs., Ms., etc.)

First Name

Middle Name

Surname, (Last Name)

Suffix (i.e., Jr., Sr., II, III)

Maiden, if applicable

Name(s) under which originally licensed in this or another state, if different from above (First, Middle, Last).

### 2. Social Security Number

U.S. Social Security Number

Please Refer to "Mandatory Addendum to License Application" on the last page of this application

### 3. Gender

☐

Male

☐

Female

### 4. Date and Place of Birth

Month

Day

Year

City and State; OR Province and Country, etc., if NOT U.S.

### 5. Home Address

It is your responsibility to notify the board of all address changes.

1st Line Address (Apartment/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

Home Phone

Email Address (Format for email address is Username@domain e.g. applicant@isp.com)

State

Zip Code

Postal Code, If NOT U.S.

Home Fax

### 6. Business Address (ONLY if it is RELATED to your license.)

It is your responsibility to notify the board of all address changes.

**This address will appear on the Department of Health web site.**

Name of Business/Work Location

1st Line Address (Department/Suite/Room Number, etc.)

Second Line Address (Number and Street)

City

Country, If NOT U.S.

Business Phone

State

Zip Code

Postal Code, If NOT U.S.

Business Fax

**7. Preferred Mailing Address**

Please check ONE

- ☐ Please use my **Home Address** as my preferred mailing address
- ☐ Please use my **Business Address** as my preferred mailing address

**10. Criminal Convictions**

Respond to the question at the top of the section, then list any criminal conviction(s) in the space provided.

If necessary, you may continue on a separate 8½ x 11 sheet of paper.

Have you ever been convicted of a violation, plead Nolo Contendere, or entered a plea bargain to any federal, state or local statute, regulation, or ordinance or are any formal charges pending? **If you answer yes and you do not provide an explanation, your application will not be processed. If you do not pass both examinations with six (6) months from the date of the BCI, a current one will need to be submitted.**

☐ Yes ☐ No

Abbreviation of State and Conviction<sup>1</sup> (e.g. CA - Illegal Possession of a Controlled Substance):

Month		Year	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If you answer yes, you must give complete

details as to what led to the arrest(s).

**11. Disciplinary Questions**

Check either Yes or No for each question.

1. Has any Health Professional license, certificate, registration, or permit you hold or have held, been disciplined or are formal charges pending? ☐ Yes ☐ No
2. Have you ever been denied a license, certificate, registration or permit in any state? ☐ Yes ☐ No



**Note:** If you answer "Yes" to any question, you are **required** to furnish complete details on the next page, including date, place, reason and disposition of the matter. You may use the space below or, if needed, on a separate sheet of paper. If you answer "Yes" to any question you **must** attach originals, or certified copies of any court documentation to this application.

**12. Affidavit of Applicant**

Complete this section and sign in the presence of a notary public.

Make sure that you and the notary public have completed all components accurately and completely.

I, \_\_\_\_\_, being first duly sworn, depose and say that I am the person referred to in the foregoing application and supporting documents.

I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice as a Medication Aide in the State of Rhode Island.

I understand that my records are protected under the Federal and State Regulations governing Mental Health Patient Records and cannot be disclosed without my written consent unless otherwise provided in the law. I understand that my records are protected under the Federal and State Laws and Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided in the regulations.

I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Nursing Assistant Advisory Board of any change in the answers to these questions after this application and this affidavit is signed.

Signature of Applicant \_\_\_\_\_

Date of Signature (MM/DD/YY) \_\_\_\_\_

The foregoing instrument was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is personally known to me or has produced \_\_\_\_\_ as documentation and did / did not take an oath.

Name of Notary (Print, Type or Stamp) \_\_\_\_\_

Signature of Notary \_\_\_\_\_

Notary Seal

Notary No/Commission No. \_\_\_\_\_

Commission Expiration Date (MM/DD/YY) \_\_\_\_\_

**13. Recent Photograph**

Securely tape or glue in this square a current 2" x 2" photograph of yourself (alone).

Photographs must be recent, passport type photo, clear, front view, full face without a hat or dark glasses.

Full length photos will not be accepted.



Write your name on the back of the photograph, and provide the date that the photograph was taken.

\_\_\_\_\_ Date of Photograph



Rhode Island Department of Health

3 Capitol Hill, Providence RI , 02908-5097

**MANDATORY ADDENDUM TO LICENSE APPLICATION**  
**Tax Payer Status Affidavit / Identity Verification**

All persons applying or renewing any license, registration, permit or other authority (herein after called "licensee") to conduct a business or occupation in the state of Rhode Island are required to file all applicable tax returns and pay all taxes owed to the state prior to receiving a license as mandated by state law (RIGL 5-76) except as noted below.

In order to verify that the state is not owed taxes, licensees are required to provide their Social Security Number, or Federal Tax Identification Number (for businesses) as appropriate. . These numbers will be transmitted to the Division of Taxation to verify tax status prior to the issuance of a license.

**Licensee Declaration**

- ☐ I hereby declare, under penalty of perjury, that I have filed all required state tax returns and have paid all taxes owed.
- ☐ I have entered a written installment agreement to pay delinquent taxes that is satisfactory to the tax administrator.
- ☐ I am currently pursuing administrative review of taxes owed to the state.
- ☐ I am in federal bankruptcy. (Case # \_\_\_\_\_)
- ☐ I am in state receivership. (Case # \_\_\_\_\_)
- ☐ I have been discharged from bankruptcy. (Case # \_\_\_\_\_)

\_\_\_\_\_  
Type of Professional License for which you are applying.

\_\_\_\_\_  
Full Name (Please Print or Type)

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Phone Number (including area code if not 401)

\_\_\_\_\_  
Date

*This form must be completed, signed and attached to your license application for processing.*